

Research Paper The Relationship Between Religious Attitude and Anxiety Caused by COVID-19 in South Khorasan Province, Iran

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ABSTRACT

Background and Objectives: Anxiety manifests as feelings of worry, stress, and physical changes, such as rapid heart rate and high blood pressure. According to the coronavirus prevention protocols, home quarantine is necessary to control the disease in society, but doing it causes a feeling of social isolation and, ultimately, different psychological effects, such as mood disorders, depression, anxiety, and mental disorders. This study aims to investigate the relationship between religious attitudes and anxiety caused by COVID-19 in the population of South Khorasan Province, Iran.

Methods: Using a web-based descriptive-analytical study, data from 507 people were voluntarily collected using a demographic information questionnaire, religious attitudes of Sirajzadeh (26 questions), and anxiety caused by COVID-19 disease (18 questions). Multivariate linear regression was used to identify the effect of factors affecting anxiety related to the disease.

Results: The results of this study showed no significant relationship between religious attitudes and anxiety in two-variable analysis (P>0.05), but in the presence of other variables in multivariate linear regression analysis, a significant relationship is observed between the dimension of the consequence of religious attitudes and physical anxiety (P=0.006). Also, the level of anxiety among women (P<0.001) in the age group 31-40 (P=0.003), married people (P<0.001), the unemployed (P<0.001), and people with a history of chronic diseases (P=0.003) was higher.

Conclusion: This study showed a significant relationship between the consequences of religious attitude and physical anxiety, as well as high levels of anxiety among different population groups. Our study revealed high levels of anxiety among different populations among these groups. In this regard, the health care system should reduce the level of anxiety among high-risk groups by using psychological interventions and strengthening the religious basis of the society using religious leaders.

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Introduction

oronaviruses (COVID-19) are a large family of viruses that can cause respiratory infections ranging from the common cold to more severe diseases, such as Middle East respiratory syndrome coronavirus (MERS) and severe acute respiratory syndrome (SARS). The outbreak

of this new virus started in December 2019 in Wuhan City, China [1]. Its signs and symptoms include fever, cough, and difficulty breathing [2]. This disease, in addition to physical problems, also causes mental problems, among which anxiety is one of the common occurrences in people, especially in patients with chronic respiratory disorders, which can significantly reduce their quality of life [3].

Anxiety appears as a feeling of unease, stress, and physical changes like rapid heartbeat, high blood pressure, trembling, sweating, and dizziness [4]. According to prevention protocols, home quarantine is necessary to control the disease in the community. Still, it causes feelings of social isolation and different psychological effects, such as mood disorders, depression, anxiety, psychotic disorders, fear, insomnia, and post-traumatic stress disorder [5]. Also, different disease peaks cause changes in society, such as closing companies, public places, and schools, which in turn can lead to anxiety, stress, and depression in people [6].

In a study conducted in Iran, 21% of Iranians experienced moderate anxiety, and more than 9% experienced severe stress during the COVID-19 pandemic [7]. Also, 45% and 25% of Turkish [8] and Chinese [9] experienced moderate to severe anxiety, respectively; as a result, people take different approaches to dealing with stress. According to past studies, psychological well-being is influenced by various factors, including social factors, economic burden, family support, social support, social capital, and religious factors [10].

Religion is a set of beliefs, practices, and language that defines a group of people searching for a specific meaning in a particular way [11]. Religion responds to many basic human needs and fills moral, emotional, and spiritual gaps [12]. In this case, people turn to religion with two positive and negative approaches [13]; people with a positive religious attitude establish a favorable relationship with God through prayer. On the other hand, people with a negative religious encounter blame God in incidents and problems, and this has been associated with a higher or lower level of mental health, respectively [14]. In some studies, a reverse relationship is observed between positive attitude towards prayer and anxiety, and thinking about God is known as a coping force against stress [15].

The coronavirus epidemic, followed by home quarantine, business closure, and changing people's lifestyles, has brought a lot of tension and anxiety to them. So, having a proper solution can play a significant role in controlling stress, and people's religious attitudes can be one of these solutions. Given the lack of research in this area, this study was conducted to investigate the relationship between religious attitudes and anxiety caused by CO-VID-19 in the population of South Khorasan Province, Iran.

Methods

This cross-sectional descriptive-analytical study was conducted to investigate the relationship between religious attitudes and anxiety caused by the coronavirus in South Khorasan Province in 2020 using the convenience method. The research environment was South Khorasan Province, and the research population was also residents of this province. The data of this study was collected electronically due to the spread of COVID-19 in society and the inability to communicate directly with people.

The inclusion criteria included being 18 years old or older, being Iranian, residing in South Khorasan Province, and being able to complete the questionnaire during the study. The exclusion criteria included unwillingness to participate in the survey, incomplete completion of the questionnaire, and completing the questionnaire earlier than one minute and later than one hour. Before completing the questionnaire, information, such as the purpose of the research was provided to all participants so they could make an informed decision about participation. They were also assured that their data would remain strictly confidential. The questionnaire was designed electronically on the Cafepardazesh social media and the website and its link were made available to the people in South Khorasan Province.

In this research, three questionnaires were used, the completion of which was completely voluntary. First, a demographic questionnaire included age, gender, marital status, education level, occupation, place of residence, smoking status, and history of chronic diseases, such as diabetes and blood pressure. The second questionnaire assessed religious attitudes, adapted by Serajzadeh (1998) [16] based on Glock and Stark's model, tailored explicitly to Islam, especially Shiite Islam.



This questionnaire consists of 26 statements that measure four aspects of religiosity, belief dimension, experiential dimension, consequence dimension, and ritual dimension. Each question has five options for expressing feelings ranging from strongly disagree (0 points) to strongly agree (4 points). Statements 20 to 26 are scored similarly, and statements 19, 17, 16, 14 and 7 are reversed. Statements 1-7 of the belief dimension (0-28 points), statements 14-19 of the consequential dimension (0-24 points), and statements 20-26 of the ritual dimension (0-28 points) are measured.

The score of the subject in each of the sub-scales and the score of each person in the total score index is interpreted as the intensity of the individual's overall religious attitude (0-104 points). The higher the person's score in the dimension, the greater the intensity of the person's religious attitude in that particular dimension. The validity of this questionnaire was obtained by Serajzadeh (1998) as 61% from the opinion of several doctoral students who were thoroughly familiar with Islam [16]. In Mehdad et al.'s study, the reliability of this questionnaire using Cronbach's α method was 68% for religious beliefs and 63% for emotional (experiential) religious beliefs, respectively [17].

Alipour et al. designed the anxiety questionnaire due to COVID-19 disease to measure the anxiety caused by the spread of the coronavirus in Iran, and it has been valid and reliable. The final version of this tool has 18 items and 2 components. Items 1 to 9 measure mental symptoms (0-27 points), and items 10 to 18 measure physical symptoms (0-27 points). This tool is scored on a 4-point Likert scale (never=0, sometimes=1, most of the time=2, and always=3); therefore, the highest and lowest scores obtained by respondents in this questionnaire are between 0 and 54. The high scores in this questionnaire indicate a higher level of anxiety in people. Using Cronbach's α method, the reliability of this tool was 87% for the mental factor, 86% for the physical factor, and 91% for the entire questionnaire [18]. Data were analyzed using SPSS software, version 24; the significance level was P<0.05, CI=0.95.

Anxiety and its areas were considered dependent variables, and the variables of religious beliefs and its areas and the participants' demographic characteristics were considered independent variables. To determine the relationship between each independent variable and the dependent variable, t-test, Pearson correlation coefficient, and one-way analysis of variance (ANOVA) were used. Also, multiple linear regression was performed with the Inter method to determine the relationship between independent variables and dependent variables by adjusting the effect of other variables. At this stage, the independent variables whose significance level was <0.2 in the bivariate analysis with the dependent variables were entered into the multivariate regression model. Data were analyzed using SPSS software version 24, and the significance level was P<0.05, CI=0.95.

Results

In the present study, 532 samples participated, of which 25 were excluded due to the need to complete the questionnaire and live in South Khorasan. Finally, 507 participants were included in the study. The Mean±SD age of the participants was 27.97±8.89, and the age range was 18 to 63 years. A total of 66.6% of the participants were female, and most were married (Table 1).

The Mean±SD anxiety caused by COVID-19 in the participants was 13.62±8.89. Regarding the central relationship of the research, the results of Pearson's correlation coefficient test showed no significant relationship between religious attitude and its areas with total anxiety and its areas (P<0.05) (Table 2).

Based on the independent t-test results, a significant difference was observed between gender and anxiety and its areas, and women had a higher mean score than men in these areas (P<0.05) (Table 3). Also, the one-way analysis of variance (ANOVA) showed a significant difference between the physical symptoms of anxiety and the participants' education level (P<0.21). The results of Tukey's post hoc-test in this regard showed that people with a middle school education level and less showed more physical symptoms of anxiety than people with a diploma education level (P<0.20).

The results of the multiple linear regression test show that the anxiety caused by COVID-19 and its areas have a significant relationship with gender, history of chronic disease, marital status, place of residence, education, the consequent area of religious attitude, and employment status. In the realm of mental symptoms, while keeping other variables constant, the average score of anxiety symptoms in women was 1.56 units (95% CI, 0.48%, 2.64%) compared to men. Also, in individuals with a history of chronic illness, it increases to 3.66 (95% CI, 0.51%, 6.81%) compared to those without underlying disease.

The regression test in the area of physical symptoms also showed that in the presence of other accompanying



Variables		No (%)		
Conder	Man	169(33.40)		
Gender	Female	337(66.60)		
	<20	96(19.7)		
	21-30	233(47.9)		
Age (y)	31-40	116(23.8)		
	41-50	35(7.2)		
	>50	7(1.4)		
	Single	202(40)		
ivialital status	Married	303(60)		
	Middle school	55(10.90)		
Lovel of advertion	High school	29(5.80)		
Level of education	Diploma	137(27.10)		
	University	284(56.20)		
Diago of residence	City	454(90.08)		
Place of residence	Village	50(9.92)		
Smoking status	Yes	25(23.8)		
SHIOKINg status	No	480(7.2)		
Chronic disease history	Yes	11(2.20)		
	No	494(97.80)		
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Table 1. Demographic characteristics and characteristics of participants by quantitative and qualitative variables

Table 2. The average score of the participants in the variable of anxiety and its areas and religious attitude and its areas

Variables		Mean±SD	
	Total religious attitude	71.70±15.33	
	Belief dimension	23.52 ±5.01	
Religious attitude and its areas	Experiential dimension	18.55±4.15	
	Consequential dimension	14.19±3.56	
	Religious practices dimension	15.65±5.60	
	Total anxiety	13.62±8.91	
Anxiety and its areas	Psychiatric symptoms	10.40±5.33	
	Physical symptoms	3.21±4.36	
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Variables		Mean±SD			
		Psychiatric Symptoms	Physical Symptoms	Total Anxiety	
Condor	Man	9.21±4.61	2.10±3.42	11.31±7.07	
Gender	Female	10.99±5.58	3.77±4.67	14.77±9.52	
F	,	P<0.001	P<0.001	P<0.001	
	<20	9.13±5.14	2.33±3.42	11.46±7.97	
4.50	21-30	10.54±5.44	2.77±3.96	13.31±8.66	
Age	31-40	11.54 ± 5.13	4.40±5.45	15.94±9.79	
	>40	9.11±5.23	3.66±4.03	12.78±8.65	
F	,	0.004	0.001	0.001	
Maxital status	Single	9.33±5.05	2.08±3.31	11.42±7.60	
Marital status	Married	11.12±5.42	3.98±4.80	15.11±9.44	
F		P <0.001	P<0.001	P<0.001	
	Middle school	10.70±6.33	4.61±5.46	15.32±1086	
Lovel of education	High school	10.10±6.44	4.13±5.62	14.24±11.41	
Level of education	Diploma	9.97±5.21	2.61±3.91	12.58±8.23	
	University	10.58±5.09	3.12±4.13	13.71±8.54	
F	,	0.68	0.021	0.26	
Diaco of residence	City	10.02±5.82	4.84±6	14.86±11.18	
Place of residence	Village	10.43±5.30	3.04±4.12	13.48±8.66	
Smoking status	Yes	9.68±4.87	7±6.49	21.45±11.57	
Smoking status	No	10.44±5.37	3.12±4.27	13.44±8.80	
Chronic discosso history	Yes	14.45±5.82	7±6.49	21.45±11.57	
	No	10.31±5.30	3.12±4.27	13.44±8.80	

Table 3. Comparison of anxiety and its areas in participants based on demographic variables

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variables, the average score of the area of physical symptoms of anxiety with the change of gender from male to female is 1.56 units (95% CI, 0.670%, 2.44%), marital status from single to married 1.21 units (95% CI, 0.15%, 2.26%), and the average score for the physical symptoms of anxiety in individuals with a history of chronic illness is 3.46 units higher (95% CI, 0.51%, 6.81%) than in individuals without this history. However, for each level increase in the education level of people, 0.49 units (95% CI, -0.005%, 0.993%) is reduced from the average score of people's physical symptoms. Also, by changing the place of residence from village to city, the average score of the area of physical symptoms of anxiety of people is 1.76 units (95% CI, -0.44%, 3.09%), and for each one-unit increase in the average score of the religious attitude domain, the average score of the physical symptoms of anxiety domain decreases by 0.17 units (95% CI, -0.05%, 0.29%).



Variables		Non-standard Beta	Standard Beta	Ρ	95% CI	R ²
Psychiatric areas	Gender (man)*	1.56	0.005	0.005	0.48-2.64	0.05
	Chronic disease history (have) [*]	3.66	0.023	0.023	0.51-6.81	0.06
Physical areas	Gender (man)*	1.56	0.001	0.001	0.67-2.44	
	Marital status (married)*	1.21	0.024	0.024	0.15-2026	
	Level of education (middle school and less)*	-0.49	0.048	0.048	-0.005-0.993	0.13
	Place of residence (city)*	-1.76	0.009	0.009	-0.44-3.09	
	Chronic disease history (have)*	3.46	0.010	0.010	0.82-6.10	
Areas of religious belief consequences		-0.17	-0.144	0.006	-0.05-0.29	-
Total anxiety	Gender (man)*	2.57	0.135	0.006	0.73-4.40	
	Marital status (single)*	2.17	0.12	0.049	0.01-4.34	0.082
	Chronic disease history (have)*	7.84	0.125	0.006	2.31-13.37	

Table 4. Results of multivariate linear regression and the effect of variables on the anxiety index and its areas

*Reference.

In terms of the average overall anxiety score, while holding other variables constant, the average overall anxiety score increased by 2.57 units (95% CI, 0.73%, 4.40%) when changing gender from male to female, by 2.17 units (95% CI, 0.01%, 4.34%) when changing marital status from single to married, and also increased by 7.84 units (95% CI, 2.31%, 13.37%) in individuals with a history of chronic illness compared to those without this history (Table 4).

Discussion

The purpose of this study was to investigate the effect of religious beliefs on anxiety caused by COVID-19 in the population of South Khorasan Province during the epidemic. The findings from the two-way analysis showed that there is no significant relationship between religious beliefs and COVID-19-related anxiety. Still, controlling for other variables in the multiple regression, a significant relationship was found between the religious beliefs consequences and the physical anxiety outcome of COVID-19. Based on this, many studies have proven the importance of the impact of religious beliefs on mental health.

The current study is consistent with the findings of Heidari et al. [19]. So, peace of mind in life, not having

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fear, sorrow, and anxiety, is always the benefit of those who believe in God and follow His guidance. Religion gives people a sense of control and efficiency. It causes hope, compensating for negativity and increasing happiness [20], so 70% to 80% of people use religious and spiritual beliefs when dealing with problems and failures in their daily lives [21]. Also, based on Koenig findings [22], religious beliefs give a person a feeling of empowerment in overcoming life's problems and tensions through their impact on the perception of stress and anxiety. Thus, people who overcome their stress by using religion in emergencies have positive feelings and less stressful situations [23].

According to the results of the present study, 8.7% of people had physical symptoms, 7.3% had mental symptoms, and in the total anxiety caused by COVID-19, 6.9% of people had severe anxiety, and 20.1% had moderate anxiety, which women experienced more than men. Similar studies conducted in Iran and other countries, such as the present study, showed that from one-fifth to more than a quarter of people experienced moderate to very severe anxiety, in which anxiety was more evident in women than in men [3, 7, 9]. This may be because women are more aware of their emotions than men and are more willing to express their fears and emotions [24].



In the studies conducted by Moghanibashi-Mansourieh and Lee et al., the highest level of anxiety was found in youth and young adults, which is similar to the results of the present study [7, 23]. In this study, with the increase in the level of education, the level of anxiety in the area of physical symptoms decreased, which was significant in the presence of other variables in the multivariate regression. In the study conducted by Wang et al., illiterate people had higher depression than people with a higher level of education [9]. Therefore, high anxiety in people with a low level of education can be because they are more affected by false news and rumors. In addition, most people with chronic diseases develop these diseases in old age, which is a risk factor for this disease and as a result, increases anxiety in them [7].

Conclusion

The results of this study showed that more than onefourth of the participants experienced moderate to severe anxiety during the pandemic, and religious attitude in the consequence dimension can play an essential role in reducing this anxiety in the physical dimension. In this regard, it is recommended to people and experts active in the field of mental health to teach people healthy behaviors and adverse psychological consequences in this field and encourage them to use alternative methods of communication, such as virtual networks, to stay in touch with family to prevent social isolation. Responsible organizations in this field, especially the national committee to combat COVID-19, should prepare appropriate protocols tailored to the religious and cultural beliefs of the people in each community, divided by city and village, occupational, age, and educational groups, to reduce anxiety at the societal level.

Ethical Considerations

Compliance with ethical guidelines

This study was approved by the Ethics Committee of Birjand University of Medical Sciences (Code: IR.BUMS.REC.1399.005) and was conducted based on the Helsinki Declaration.

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Authors' contributions

Study design and supervision: Mohammadreza Jani and Hamid Nazari; Data collection: Hamid Nazari; Data analysis: Ali Arabahmadi; Writing the original draft: Mohammadreza Jani.

Conflict of interest

The authors declared no conflict of interest.

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